

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

FEDERAL SECURITY AGENCY  
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No.

34852

8963

Registration District No. 312

Primary Registration District No. 1003

Registrar's No.

1. PLACE OF DEATH: (a) County St. Louis, Mo.  
(b) City or town St. Louis, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. Louis City Hospital-Max C. Starkloff  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 0 (Specify whether  
In this community 0 years, months or days)

3. (a) PRINT FULL NAME ORA WILLIAMSON

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 0 5. Color or race White 6. (a) Single, widowed, married, divorced Widower 2  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased: March 31st. 1871  
(Month) (Day) (Year)

8. AGE: Years 77 Months 6 Days 12 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace: Iowa \_\_\_\_\_  
(City, town, or county) (State or foreign country)

10. Usual occupation Maintenance

11. Industry or business Cindrell Theatre

12. Name Frank Williamson  
13. Birthplace Ohio \_\_\_\_\_  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace Unknown \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant John Williamson  
(b) Address 3022 Ohio Ave  
17. (a) Burial (b) Date thereof 10-16-1948  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sunset Burial Park  
18. (a) Signature of funeral director Regenbush Bros.  
(b) Address 6409 Gravois Ave  
19. (a) OCT 16 1948 (b) J. B. Lassiter  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County 000  
(c) City or town St. Louis (If outside city or town limits, write "RURAL")  
(d) Street No. 3022 Ohio Ave Memorial (If rural, give location)  
(e) Citizen of foreign country? 24 (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 13th  
year 1948 hour 8 minute 20 A. M.

21. I hereby certify that I attended the deceased from 10/7/48  
\_\_\_\_\_, 19\_\_\_\_, to Oct. 13th, 1948.  
that I last saw him alive on Oct. 13th, 1948.  
and that death occurred on the date and hour stated above.

Immediate cause of death Thrombosis of Middle Cerebral Artery 7 days  
Due to Arteriosclerosis  
Due to 8/3

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy Sume

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? W. M. Larkin (Specify type of place) (b) Means of injury M. D. D.  
23. Signature 1515 Lafayette 10/13/48  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

.....  
working under my personal supervision.

..... Registered Apprentice No. ....

Signed.....

.....  
Licensed Embalmer No. ....

.....  
P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**